THE ROLE OF THE NURSING AND MEDICAL RECORDS TECHNICIAN IN THE MEDICAL FILES OF PATIENTS IN HEALTH FACILITIES

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Abstract: *The aim of the current study is, the role of nursing in serving community health, the role of electronic medical records in serving patients, the benefits of electronic medical records for medical staff. The questionnaire was created electronically via the Google Drive program, and then it was distributed via mobile phone on the social networking program (WhatsApp). Using e-mail for all participants to respond to the questionnaire. 600 questionnaires were distributed to all mobile groups, and 550 questionnaires were received on the researcher's e-mail. (The target group is residents of the Holy City of Mecca, aged 25-60 years).*
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1-INTRODUCTION:

The nurse is the person responsible for nursing care at the various stages of patients' presence, and he holds a nursing certificate after studying at least four years in the College of Nursing and has become qualified and licensed to practice the nursing profession in addition to his ability to work as a member of a medical team [1][2][3]. Nursing is very old, as it is older than medicine itself. Nursing began at the dawn of history as a social service that arose from the natural instinctive sense of protecting and caring for the family. A mother's care for her newborn in health and illness is a type of nursing, and a woman's assistance to women in childbirth existed before medicine was known. When a person searches the history of nursing, he finds that nursing skills are very ancient. Nursing skills have been known since humanity has known. The mother was considered the first nurse known to humanity. She had been taking care of the newborn since his birth, and she had also taken care of the sick, the wounded, and the elderly in the family. Although the noble goals of nursing have continued throughout history, the practice of nursing has changed under the influence of factors in different societies and medical development until nursing emerged as a profession with its own origins and academic degrees. It is indispensable to any society and medicine cannot be practiced without it at any time. An electronic medical record is a medical record in digital format. Electronic medical records in health informatics are considered one and the same form of electronic health records, but in general use these two terms are used synonymously [4]. Medical records, or what we call the patient file, are one of the pivotal points on which the process of providing health care within hospitals and between various types of medical institutions depends. The importance of these records stems from the importance of their role in preserving all patient information, including basic and comprehensive medical data for all examinations and diagnoses that have been performed. Treatment, follow-up reports, and important medical decisions. For many decades, the nature of medical records remained fixed in the form

of a file or group of papers on which information was written by hand, until developments occurred during the past forty years. One purpose of electronic medical records (EMRs) is to increase the accessibility and sharing of health records among authorized individuals. Privacy of information collected during health care processes is necessary because of significant economic, psychologic, and social harm that can come to individuals when personal health information is disclosed. [5,6,7] With remote access to distributed health data, or the pooling of health data from multiple sites in a central repository, the potential for loss of information privacy is greater than in isolated EMR systems, or in systems with paper medical records, when proper safeguards are not taken. With appropriate safeguards, however, computer-based medical records may actually offer more security than traditional paper-record systems. Applicable security technologies exist and have proved effective in the banking and military sectors. As a result of the link between electronic records and the integration of their content with hospital information systems and their various services, including laboratories, diagnostic radiology departments, pharmacies, various therapeutic methods, multiple surgeries, and others, these records have become a center of power in providing health care and helping the doctor perform his work better, as it provides all the information. The patient's medical information is in an integrated and harmonious form, and the difficulty of this task appears in light of the tremendous growth in the quantity and quality of medical information and the diversity of its sources. This information is no longer merely verbal and descriptive texts of the patient's condition or the progress of his recovery, but rather, as we mentioned, it includes many modern forms. From images of information and advanced means of displaying it, the patient's data and medical information today include complex numbers from the results of blood tests, hormones, enzymes, and compounds, diagnostic x-rays, pictures of parts of the body - such as Gastrointestinal endoscopy and others. Its electronic content enables the doctor to distinguish signs of

danger and harbingers of the disease in its early beginnings and before it reaches a stage that is difficult to treat, or to guide the doctor to the optimal choice and help him make the right decision in prescribing the appropriate treatment, examination, or surgery, instead of distracting his mind by listing hundreds of pieces of information. Numbers and abstract facts, so modern information systems have provided medical records with special capabilities to process and analyze data, making them able to distinguish pathological numbers in laboratory results by measuring their exceeding the recognized normal limits, as well as linking those values and numbers to the patient's age, gender, and original health condition, as has become It is possible to make automated comparisons between these results and previous ones to evaluate the patient's response to a specific treatment or surgery. [8]. Developing the presentation of all information and data was not what preoccupied the minds of the specialists, but what preoccupied them in reality was how to arrange that presentation and coordinate its priorities in terms of severity, impact, and importance in order to support those records.
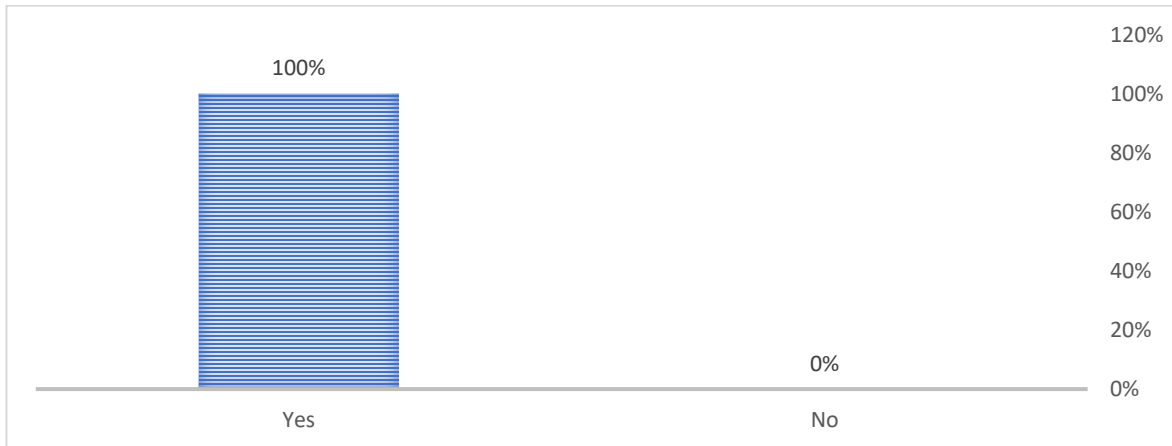
2-MATERIAL AND METHODS:

The study started in (the holy city of Mecca in Saudi Arabia), began writing the research and then recording the questionnaire in June 2023, and the study ended with data collection in October 2023. The researcher used the descriptive analytical approach that uses a quantitative or qualitative description of the social phenomenon (The role of the nursing and medical records technician in the medical files of patients in health facilities). This kind of study is characterized by analysis, reason, objectivity, and reality, as it is concerned with individuals and societies, as it studies the variables and their effects on the health of the individual, society, and consumer, the spread of diseases and their relationship to demographic variables such as age, gender, nationality, and marital status. Status, occupation [9], And use the Excel 2010 Office suite histogram to arrange the results using: Frequency tables Percentages [10]. A questionnaire is a remarkable and helpful tool for collecting a huge amount of data, however, researchers were not able to personally interview participants on the online survey, due to social distancing regulations at the time to prevent infection between participants and researchers and vice versa (not coronavirus participation completely disappearing from society). He only answered the questionnaire electronically, because the questionnaire consisted of ten questions, all of which were closed. The online approach has also been used to generate valid samples in similar studies in Saudi Arabia and elsewhere [11]

3- RESULTS AND DISCUSSION:

The percentage of approval to participate in the research by the targeted people (residents of the city of Mecca between 25-60 years old) was 100%, while the ages of the participants were as follows: 25-34 years old, 18.5%, 35-44 years old, 37%, 45- 54 years old, 44.4%, while there were no participants aged 55-60 years. As for their gender, the percentage of males was 48.1%, and the percentage of females was 51.9%. As for the nationalities of the participants, they were 88.9% Saudis, and 11.1% non-Saudis. As for the professions of the participants, they were as follows: student: 7.4%, government employee: 70.4%, the percentage of private sector employees and housewives was equal (10%), while freelancers were 2.2%. As for their educational status, it was as follows: holders of a primary certificate 0%, intermediate 0%, secondary school 22.3%, university 29.6%, diploma 40.7%, as for holders of a master's degree and doctorate (equal) 3.7%. Regarding the first question, do both nursing and medical records technicians play their role in serving patients with regard to medical records? Yes 96.3% and no 3.7%. The medical records technician maintains medical records, while the nursing technician observes patients, writes down symptoms and changes in vital signs, administers medications, and notes their side effects. Yes 100% and no 0%. The third question: Does the medical records technician retrieve all medical records used in the hospital and coordinate with the relevant departments in this regard? Yes 93.6% and no 7.4%. The fourth question about the nursing technician who uses electronic medical records to access patient information quickly and efficiently? Yes 100% and no 0%. Question 5: What medical records help the nurse with mobile health applications in telehealth platforms? Yes 100% and no 0%. The sixth question: Does the medical records technician arrange patient medical record forms according to a specific and specific sequence? Yes 96.2% and no 3.8%. The seventh question: How does the medical records technician work to complete the missing information and forms in coordination and cooperation with the doctors and nursing staff? The answer is the same as the answer to the previous question. The eighth question about the medical records technician who records emergency and forensic cases in the ambulance and emergency department and opens, saves and indexes medical files? Yes 92.3% and no 7.7%. The ninth question: Does nursing play the role of health education for patients? And talk to them about taking an active role in managing their health? Yes 96.2% and no 3.8%. The tenth question: How does the medical records technician prepare appointments,

record cases, and control referrals to outpatient clinics? Yes 96.3% and No 3.7% (Figure No.1)

Figure No.1: Opinions and attitudes of questionnaire participants regarding the role of nursing technicians and medical records in patient files

4-CONCLUSION:

We found from this study that, The importance of the role of nursing and medical records technicians in providing medical services to patients, especially in the field of completing information and evidence for patients, which has greatly helped in the way patients communicate with the medical staff.

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